

ANNUAL REPORT 2012



FAIR PRACTICES OFFICE

**An independent office
working to promote fair
practices at the Workers'
Compensation Board
of Saskatchewan**

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Terms commonly used in this report

Board - the Board of Directors

FPO - Fair Practices Office(r)

WCB - Saskatchewan Workers' Compensation Board

MESSAGE FROM THE FAIR PRACTICES OFFICER

It is my privilege to present the 8th Annual Report of the Fair Practices Office for the year ending December 31, 2012.

The Annual Report is a review of last year's accomplishments and an opportunity to look to our future plans. This year also marks the end of my first full year as the Fair Practices Officer.

Last year, the FPO again looked for ways to help with solutions to service issues. Those issues came to us from workers and employers, and others who use WCB services. We remain mindful of any systemic issues that may need to be addressed. We understand that clear, fair policies and procedures help the timely and fair administration of benefits — 'good paper makes for good decisions.'

The past year was challenging. We had the greatest number of calls and complaints in our history. The first half of the year was particularly busy. We received 241 complaints, up from the three-year average of 180, or a 33.9 per cent increase. In the second half of the year, complaints fell to the rate seen in previous years. The year ended with a total of 484 new calls and 47 re-opened files, for a total of 531 calls, 64 more than in 2011. This is a 13.7 per cent increase year-over-year, or a 17.5 per cent increase over the three-year average.

We also saw a significant increase in the number of complaints for each call. A total of 790 complaints were received. This is a 22.3 per cent increase of total complaints over 2011 levels.

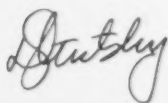
The most significant reason for complaints was the introduction of a new claims management system. This impacted staff resources and service delivery in a number of areas. The implementation phase of the new system has ended. We should start to see the benefits of the new system in 2013. Also in 2012, the Provincial Ombudsman conducted an advertising campaign, which raised the awareness of complaint mechanisms. And we made a concerted effort to promote our services both internal and external to the WCB.

Complaints about communication and service timeliness saw a large increase in 2012. This is an increasing and alarming trend. The FPO experienced similar issues in 2012 with two such cases reported on in the Case Summaries section of this report. We continue to raise these issues to understand the problem areas. We also continue to recommend that the right resources are available in adequate numbers to improve service delivery in those areas.

The greatest area of complaint seen by our office was disagreement with decisions. Often we can help workers and employers to understand those decisions and the options to work through those disagreements. Our statistics indicate that close to 70 per cent of the time we provided information to support the decisions made on the files.

Along with the very able and efficient Intake and Inquiry Officer — the office could not run without such a capable staff member — I have enjoyed a positive and productive working relationship with the staff at WCB. With their cooperation, we will continue to ensure all stakeholders are provided with fair processes and fair treatment.

I look forward to again assisting injured workers and employers in the coming year.



Dana Stutsky
Fair Practices Officer

OVERVIEW

Establishment of the Office

The FPO was first recommended by the James Dorsey Review of 2000. Dorsey envisioned *"the establishment of a Fair Practices Office that will assist our clients with disputes and complaints by steering them through the process to the right place. In addition, the FPO will investigate complaints and tabulate statistics that can point to the need for process and or policy changes"*.

The Saskatchewan Workers' Compensation Act Committee of Review 2001 Report in referencing fairness, cited Section 21.1(1) of *The Workers' Compensation Act, 1979* (the Act) and its requirement that *"The Board shall: (a) treat workers and their dependents in a fair and reasonable manner"*. The Report also referenced and supported the recommendation of the James Dorsey Review of 2000 to establish the FPO.

In September 2003, the FPO was officially established with the appointment of the first Fair Practices Officer. During its first six years, the FPO operated on the basis of a Mandate Statement provided by the WCB Board Members. The role and mandate of the FPO was more formally defined through Policy 05/2009 in September 2009. Further clarification was provided by Board Members with the approval of Policy 15/2010, which took effect on July 1, 2010. The policy confirms that the Fair Practices Officer is appointed pursuant to Section 21(1) of the Act and has the power to conduct inquiries pursuant to Section 27(1) of the Act. The complete policy is available in chapter 9.5 of the WCB Policy Manual.

Role and Mandate of the FPO

The FPO has a mandate to:

- Receive, investigate and resolve complaints about unfair practices in all areas of WCB service delivery raised by workers, employers and external service providers.
- Identify complaint trends, policy matters and systemic issues and make recommendations for improvements.

If the Fair Practices Officer determines that an unfair practice has occurred, she may seek to resolve the issue at the most appropriate administrative level of the WCB. If a remedy is not implemented, she will raise the matter to senior management levels of the WCB, including the Chief Executive Officer. Unresolved issues are reported to the Board Members.

The Fair Practices Officer may, on her own initiative, investigate, identify and make recommendations on systemic issues. These are issues that affect more than one file and occur on an ongoing basis. Findings and recommendations initially will be presented to senior administration within the WCB, including the Chief Executive Officer and then to the Board Members.

Authority of the FPO

The FPO has jurisdiction to investigate all areas of WCB service delivery including, but not limited to:

- Delays in adjudication, communication, referrals or payment.
- WCB staff conduct.
- Spoken and written communications.
- Implementation of appeal decisions.
- Employer services.
- Benefit payments.
- Wrong application of policy.

Complaints NOT within the Authority of the FPO

A complaint is not within the jurisdiction of the FPO if it is about:

- The conduct or a decision of the Board Members.
- Changes to the Act or its regulations.
- An issue outside of the jurisdiction of the WCB.
- An issue under appeal.
- An issue being handled by the Office of the Workers' Advocate, unless the Office of the Workers' Advocate requests that the FPO review the complaint.
- An alleged illegal or fraudulent act. Allegations of this nature are referred to the investigative unit within Internal Audit.

Reporting

The FPO reports directly to the Board Members through the WCB Chairperson. The FPO reports quarterly, or more frequently if requested by the Board Members or the FPO.

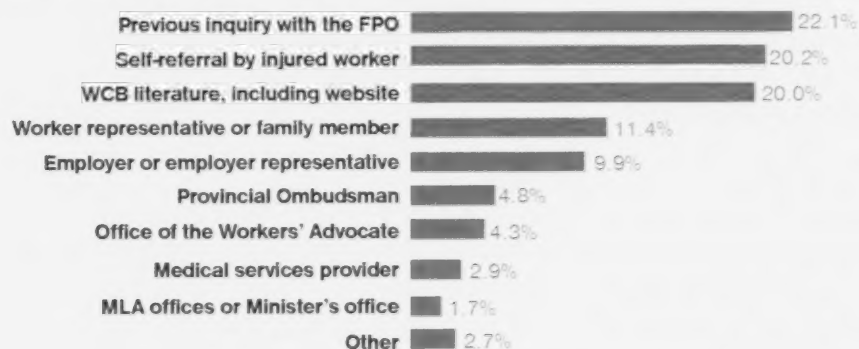
The FPO publishes an independent annual report that outlines the activities of the office. Statistics and case summaries are provided to show the type of work the office performs on a regular basis.

2012 — Activities during the year

- Attended and hosted an information table at the WCB's Compensation Institute in Regina
- Attended the WCB's Annual General Meetings in both Regina and Saskatoon
- Presented ten information sessions to WCB Operations staff in both Regina and Saskatoon
- Attended the Canadian Association of Workers' Advisors and Advocates (CAWAA) Annual Meeting in Regina
- Attended the Association of Workers' Compensation Boards of Canada (AWCBC) Learning Symposium in Whitehorse, Yukon
- Participated in regular teleconference meetings with the Fairness Working Group (counterparts in other WCBs from British Columbia, Manitoba, Ontario, Newfoundland and Labrador, and Nova Scotia)
- Attended and hosted an information table at the Saskatchewan Federation of Labour Annual Convention in Regina
- Attended 'Managing Unreasonable Complainant Behaviour' training seminar for Ombudsmen in Montreal

How do people find the FPO?

Throughout 2012, we asked callers how they learned about the FPO. This is how they replied:



Through 2012 and into 2013, we put a priority on making certain that the stakeholders who might benefit are aware of our services. This is being done through internal and external communication, including information sessions and hosting information tables at various events.

We are available via telephone, letter, or email and can also meet with complainants if needed. Contact information is on the WCB website at wcbsask.com and on the back cover of this report.

CASE SUMMARIES

The following case summaries are examples of inquiries completed by the Fair Practices Office. Names are not provided to protect the privacy of the individuals who brought these concerns to the FPO.

CASE SUMMARY 1 — Wage loss recalculation

One of the common complaints during the first half of the year related to recalculation of wage loss benefits for injured and disabled workers.

When the new claims management system was implemented in February, there were some areas that were not fully functional. One was the ability to complete wage loss recalculations when new or additional wage information was known. Another was the ability to correct a mistake in the original wage loss calculation. As a result, some recalculations were done manually and some were set aside to be done once the new system was fully operational. This created a number of concerns and calls to our office. Unfortunately the information provided by WCB staff to the affected injured workers was not consistent across the WCB. This created even more concern for some workers.

The following case summary is an example of one such complaint.

A worker called our office to complain that he felt the decision to reduce his wage loss payments was unfair. He had received a letter about this decision. Talking with him, it was clear that he did not understand the reasons for the decision. He indicated he was not back to full-time work or earning as much as he had been before his injury.

When we investigated, we learned that Section 70(4) of *The Workers' Compensation Act, 1979*, (the Act) had been used to make the decision. Section 70(4) applies to workers:

- Who were receiving wage loss benefits at 26 weeks after their injury, and
- Who had worked for less than 12 weeks with their pre-injury employer.

Section 70(4) had been applied correctly. However, it appeared the calculation of the worker's wage rate had been done incorrectly.

When the worker made his claim, his salary at the time of his injury was used to calculate his wage loss benefit. However, Section 70(1) of the Act allows for the calculation to be based on "the greater of" either:

- The wage he was earning at the time of his injury, OR
- A weekly average of his total earnings from the 12 months immediately before his injury.

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We learned the worker's prior 12 months of earnings had not been looked at. Considering what the worker reported he had earned, it was possible that he was entitled to a greater wage loss benefit, dating back to the beginning of his claim.

The worker agreed to talk to his Case Manager's Team Leader. The Team Leader agreed to look into the original calculation of the wage base. Unfortunately, there were other complicating factors on the worker's file. With the partial implementation of the new claims management system, a recalculation of the worker's wage base dating back to the date of his injury was delayed.

We followed this complaint and noted a decision regarding the wage base calculation. The worker continues to disagree. With help from the Office of the Workers' Advocate, he has filed an appeal.

CASE SUMMARY 2 — Two WCB accredited service provider lists

A worker approached me while our office was hosting a public information table. He said he had a hearing loss and was waiting for his permanent functional impairment (PFI) to be assessed. He questioned why it was taking so long.

I reviewed the file and it appeared the necessary medical information was there to complete the assessment. I contacted the Team Leader. He indicated that while the worker indeed had a hearing test, it had not been done by an Audiologist on the WCB accredited provider list. This was required before the PFI assessment could be done. The Team Leader provided me with a list of the accredited providers. It contained a number of Audiologists in the worker's home location, but the Audiologist that the worker had seen (and received his hearing aids from) was not on that list.

I told the worker what I had learned. He said he had received an accredited provider list from the WCB and the Audiologist he had seen was on the list provided to him. This information was reviewed further and it was discovered there were two WCB lists. The providers on these lists were different.

I brought this to the attention of the Manager of Health Care Services. She indicated that her department routinely uses and keeps one of the lists up to date, whereas the second list was older and not often updated or used by the Health Care Services staff.

It appears the appropriate updated list was sent to the worker and that he chose his Audiologist from that list. The list the Team Leader provided to me was the old dated list.

Having two lists with different information can cause confusion and delays both for workers and WCB staff. A recommendation was made to both the Manager of Health Care Services and the Director of Operations to have one of the lists deleted and to have only one list available.

CASE SUMMARY 3 – Cost relief

Employers requesting cost relief became a significant issue toward the last half of 2012. It is the WCB's practice to routinely review claim files to learn if specific factors exist that delay a worker's recovery. If so, the employer is entitled to 'cost relief'. This means the employer's account is not charged the costs of that aspect of the claim and subsequent calculation of their experience rating. Cost relief may be provided for other reasons, too.

For a number of reasons, there was an increase in requests for cost relief towards the end of the year. This stretched available WCB resources, creating lengthy delays before decisions were made. The following is an example of one such file.

I received an email from an employer about delays she encountered related to cost relief. The employer said she had three files where cost relief should be considered. She was frustrated that she had to ask about cost relief. She felt it should be considered by the Case Management staff as a matter of practice. Once she made the requests, there were significant delays before a decision was made. In one case, the employer indicated she had made both a verbal and written request more than a year earlier with no decision. Costs continued to be charged to her experience rating. No decision meant she was unable to appeal if she disagreed with the decision.

Two WCB policies might apply to this request.

- Policy 01/2000 speaks to what the WCB does related to pre-existing medical conditions that may impact a work injury, as per Section 50 of the Act.
- Policy 21/2010 speaks to what occurs when cost relief to an employer is provided due to a pre-existing condition.

Policy 01/2000 allows for partial cost relief if the recovery of a work injury is delayed because of aggravation of a pre-existing condition. Also, cost relief may apply if a pre-existing condition was accelerated due to the work injury. The procedure says that Operations staff is responsible for applying the policy as soon as possible after learning there is a pre-existing condition that may affect the recovery of the work injury.

In this case, the WCB was aware that the worker had two previous back surgeries and was claiming a back strain injury. The application of the pre-existing conditions policy may apply. The employer discussed this information with the Case Manager in a telephone call. With no decision made, the employer sent a follow up letter to the Case Manager requesting cost relief. With still no decision, the employer again sent a written request for cost relief. After almost 15 months from the date of the original request, the employer called our office.

The employer was encouraged to continue to communicate with the Case Manager and Team Leader, as it appeared the information was on the file for a decision to be made. The employer did meet with the Case

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Manager and was told that cost relief would be provided and a letter would be forthcoming. As this did not occur, I met with the Director of Operations to review this file as well as a number of other complaints by other employers about the delays related to decisions on cost relief. He acknowledged he was aware that these delays were occurring and were of a significant issue to some employers and employer representatives.

In the meantime, the employer in this case was advised by the Case Manager that the verbal decision to provide cost relief was made in error and more information was needed before a decision could be made. The employer sent an email to the Vice President of Operations expressing her dismay. I also met with the Vice President of Operations who assured me the situation was being reviewed and that a plan was in the works to alleviate this issue.

Seventeen months after the initial request to review the file for cost relief, a written decision was provided denying all cost relief. As the employer disagreed with the decision, she was able to proceed to appeal.

CASE SUMMARY 4 — Decision letter

One common complaint workers and employers have is not receiving letters for decisions made on their files. This means the worker or employer:

- Is not completely aware of the decision,
- Does not know on what basis a decision was made, the applicable Section of legislation or policy or procedure, and
- Is not able to make the decision to appeal if they disagree.

The following is an example of one such file.

An employer's representative called our office. It appeared a worker's claim had been accepted and benefits for wage loss and medical treatment were being paid, but the employer had not received any notification or letter. The representative indicated they may wish to appeal. However, with no information about what was accepted or why, they could not make an informed decision whether or not to appeal.

In discussion with the Team Leader, he agreed that the employer (as well as the worker) should have been notified in writing of claim acceptance when the claim was accepted, some three months earlier. The file was transferred to a Case Manager. The matter was discussed with the Team Leader in that area because the letter still had not been sent. Although there was agreement that a letter was to be sent, it was delayed further until after contact with the Director of Operations.

CASE SUMMARY 5 — Decision denying treatment costs reasonable

A worker called to say she was upset that the costs for her physiotherapy were denied. The worker explained she had been receiving chiropractic treatments since her injury about six months earlier. She was not improving and had been referred for physiotherapy.

A file review found that the chiropractic clinic billed the worker's group health coverage plan, rather than the WCB. It was explained to the worker that without the medical reports, the WCB was not aware she had continued to have treatment. The WCB had assumed her medical treatment had ended months earlier with full recovery.

The worker agreed she would make certain that accurate medical information was submitted to the WCB for a further review of coverage.

CASE SUMMARY 6 — Dependent children entitled to all benefits

We received a letter from the mother of two minor children, whose father was fatally injured at work. She felt the children should receive a greater portion of their late father's benefits. The children were receiving benefits according to a maintenance order from many years earlier. The children's mother felt that because their father had been earning a greater income, they should be entitled to a greater benefit.

The related sections of the Act and applicable policies and procedures confirm that:

- When dependent children do not live together as a family unit, the benefit amount may be divided as the WCB considers just and equitable, and
- That the WCB will pay on the basis of a court or similar order.

Therefore the decision of benefit amounts payable for these dependent children was correct.

The file review suggested that payment of additional benefits for the children for their potential post secondary pursuits (per Section 85 of the Act) was incorrectly denied. This was raised with the Team Leader who felt the legislation had been applied fairly and the children were not entitled to the additional benefits. I continued to be of the opinion the children were entitled. I took this issue to the Director of Operations. Upon review, it was agreed that the children, by virtue of their financial dependency on their late father, were entitled to additional post-secondary benefits. A letter was sent to their mother.

CASE SUMMARY 7 — Time loss paid for recurrence not a new claim

A worker called our office to say that she had been off work for a little over a week and she had not been paid any wage loss benefits for that time period. She explained she had originally hurt her foot at work and was off work for about two months. After a graduated return to work, she returned to full duties. She continued with physiotherapy treatment during her initial recovery, the graduated return to work and for three weeks following her full return to work.

She returned to full work duties for nine days and had an increase in symptoms. Her medical care providers recommended she take another 10 days off work to allow a further healing of her foot. She indicated she gave this information to the WCB and had been denied further benefits. The decision letter indicated this was because there was no new injury to require time off work. The worker reported she had explained that it was not a new injury to her Case Manager, who sent a further letter, again denying wage loss payment.

A file review showed the Case Manager did not understand that the worker had been off work for a recurrence of her injury and that what was being claimed was not a new injury, but a recurrence of the initial injury.

I raised this with the Team Leader. After waiting a number of months, the issue had not been reviewed or resolved. I raised it with the Director of Operations. The issue was reviewed. As all the information was available, it was agreed the wage loss benefits would be paid. This happened almost nine months after the worker's time off work.

CASE SUMMARY 8 — Costs split between two employers

An employer called saying he was recently advised that costs for a claim would be charged against his experience rating. He felt this was unfair. He explained the worker had not worked for him since 2007. He felt the current injury most likely was related to the worker's current employment and not what he had been doing five years earlier. The employer said the worker had worked for his company for more than 10 years. The worker had never reported any kind of injury. The employer also had concerns that the worker's injury was related to his active lifestyle and leisure pursuits.

A review of the file showed the decision was to charge all claim costs to the employer when the worker first sought medical attention for the condition. The medical information available showed this happened in 2006, while employed with the employer who complained. The medical status of the worker's condition had changed since 2006. The worker now required surgery. The employer felt it was not reasonable to charge all the claim costs to his company. He felt that the employer for the last five years should bear responsibility for the injury.

This was discussed with the Team Leader. He reviewed the situation and felt the original decision of charging all the claim costs to the original employer to be the correct one. This was also discussed with the Director and Vice President of Operations, with no change to the decision. The employer still

disagreed. He presented an appeal to the Appeals Department. The Appeals Department partially agreed with the employer and decided that the claim costs were to be divided equally between the past and current employers. The employer continues to disagree. He is in the process of appealing to the Board Appeal Tribunal.

CASE SUMMARY 9 – Caution status and provision of in-home services

A worker called our office with concerns that his wage loss payment and personal care benefits were delayed. The worker had a recent partial leg amputation and needed money to pay for extra care while recovering. Unfortunately, this was during the conversion to the new claims management system. His payments were delayed, even though they were scheduled to be paid.

During the file review, it was noticed that the worker also might need permanent ongoing services in the home. Arrangements for an in-home assessment had not been done or contemplated. When questioned, the Case Manager explained that the worker had a caution designation on his file, and the Vocational Rehabilitation Specialist refused to conduct an in-home assessment.

The WCB uses a caution designation system to place an alert on a file where there are health and safety issues for WCB staff contacting particular workers. It is a five-level designation system to provide specific advice about the caution or concern. It can range from profane language, to threatening behavior, up to having charges laid or injunctions in place. The type of client contact that is considered safe and acceptable for the ongoing communication and management of the file is included, too.

It is regrettable to put limits on client contact, but sometimes it is necessary for the health and safety of WCB staff. The process allows for notice to go to the affected worker, outlining the unacceptable behaviour, and what contact or interaction will be allowed to take place in the future. It also allows for a re-evaluation of the caution designation at regular intervals, depending on the caution level.

In this case, there was a caution level one designation on the worker's file, which indicates foul language, with no restrictions for communication or contact. A further review of the events leading up to the caution revealed the caution was added at the worker's request in 2006 because he said he didn't want to talk to WCB staff. Although the process allows for a review of this caution designation at one-year intervals, it was done only once in 2007 and the caution had remained on the file for the last six years. WCB staff had never noted any behavior to activate a caution designation.

A caution level of one would not limit the WCB staff from attending an in-home assessment. If the staff member felt their health or safety was at risk, there are other options available to complete the assessment and put an action plan in place. These include attending the assessment with another person or engaging the services of an external service provider. The Team Leader was not available and this was discussed with the Director of Operations. It was agreed an external service provider would attend the worker's home and complete the assessment. This was done approximately seven months following the amputation.

As a result of this file review, our office has started a systemic review of all caution designated files which will be completed in 2013.

COMPARATIVE STATISTICS

for the calendar years 2008 through 2012

Number of Complaints / Inquiries Received

	2012	2011	2010	2009	2008
Complaints received	484	432	425	407	434
Re-opened	47	35*	33	25	39
Total	531	467*	458	432	473

* The 2011 report incorrectly shows 44 files reopened and a total of 476 inquiries received.

Source of Complaints / Inquiries (%)

	2012	2011	2010	2009	2008
Injured workers	88.6	88.4	93.2	92.9	83.6
Employers	10.5	10.2	5.9	6.9	10.4
Other	0.9	1.4	0.9	0.2	6.0
Total	100.0	100.0	100.0	100.0	100.0

Category of Complaints / Inquiries*

	2012	2011	2010	2009	2008
Disagree with decision	425	355	338	275	332
Information requests	148	128	131	126	120
Timeliness & process delays	113	81	68	65	76
Communications/service issues	103	81	75	55	96
FPO issues (systemic)	1	1	1	2	1
Total	790	646	613	523	625

* More than one complaint can be registered per inquiry.

Resolution (closed files)*

	2012	2011	2010	2009	2008
Completed by FPO without referral	284	243	262	276	263
Called WCB for clarification	76	52	52	30	38
Referred to WCB for review	123	133	111	101	133
Total	483	428	425	407	434

* One file remained open at the end of 2012.

Outcome of Referrals to WCB

	2012	2011	2010	2009	2008
Decision changed	20	28	20	23	18
New action taken	93	92	81	74	112
Reviewed — no change	10	13	10	4	3
Total	123	133	111	101	133

Response Time to Close (%)

	2012	2011	2010	2009	2008
0-7 days	72.9	73.1	71.5	75.2	75.1
8-30 days	17.8	17.8	19.1	16.0	18.9
Over 30 days	9.3	9.1	9.4	8.8	6.0
Total	100.0	100.0	100.0	100.0	100.0

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